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ABSTRACT

In late adolescence and early adulthood, an ideally developing woman learns to cope with the world outside her family of origin and acquires a sense of identity that is stable and largely positive. Individuals with severe early trauma may have difficulty completing adolescence. Incest is one childhood trauma that can either be mastered in late adolescence or carried into adulthood with the potential for creating disturbances. Late adolescence-early adulthood would appear to be the age when incest victims are least likely to seek psychotherapy, instead relying on repression or suppression to cope with the incest experience. Incest victims may also use avoidance, acting out, and denial mechanisms and may resort to drugs and alcohol. Interpersonal crises during late adolescence may cause victims to be briefly shaken out of their denial stance. Case studies of incest victims in psychotherapy illustrate the use of denial mechanisms which were destined to break down. A victim may feel strongly attached to her mother, and at the same time, feel deeply ambivalent about her. The therapist must allow the client to work through her feelings about the mother-daughter relationship. Other themes that might be uncovered during psychotherapy include the repeated occurrence of intense romantic relationships which are ultimately destructive, and the repetition of rescue fantasies. Whether in group or individual therapy, the young incest victim needs a caring adult to relate to as she separates from her mother and revises her faulty identity formation. (NB)

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Psychotherapeutic Approach to Incest-Related Disturbances in Adolescents and Young Adults

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In late adolescence and early adulthood (ages 15 to 25), an ideally developing young woman learns to cope with the world outside her family of origin. She gradually separates from her parents, both physically and in an important emotional sense, forever losing her childlike dependency upon them for her sense of security and self-worth, but maintaining a feeling of warmth and connectedness, even from a distance, and gaining the ability to relate to them in an adult-to-adult manner. In the process, she establishes extrafamilial relationships that help her to effect the separation without becoming depressed; commonly, she first enters an adolescent peer group of girls and from this position of relative safety experiments with romantic-sexual relationships that are initially brief and stormy but develop into longer and more committed relationships that eventually enable her to establish her own family. The demands of her transition to adulthood are not only internal-emotional, but also external-instrumental in nature since she is expected to complete her formal education and learn an occupational role that will allow her to achieve economic security in an age when complete dependence on a husband-provider is viewed as less possible, and also less desirable, than in former times (Blos, 1962; Deutsch, 1967; Lamb, 1978; Miller, 1974).

Having completed the separation-individuation phase of late adolescence, the emergent woman has also acquired a sense of identity that is stable and largely positive--she has formulated

enduring answers to questions like, "Who am I?," "What am I capable of doing?," and "What do I deserve to get from life?" At 15, her identity was fluctuating and very susceptible to change in response to perceived judgments by others, while at 25 the set of basic assumptions that we call identity or character is much more stable, albeit not quite set in stone (Blos, 1962; Dashef, 1984; Lamb, 1978).

Despite a cultural tendency to malign the adolescent girl, I think it is safe to assume that the majority complete their voyage to adulthood without developing significant psychological disturbance--or causing it in others! Some authors, most notably Blos (1962), have addressed the question of blocked or miscarried adolescence. It has been noted that individuals with severe early trauma may have special difficulty completing adolescence. Such persons may make unconscious efforts to work through their pain by repeated relationships that somehow recapitulate the traumatic situation and allow a gradual sense of mastery; they may make a neurotically determined selection of mates or occupations; or they may choose avoidance as a strategy, repressing awareness of the trauma or escaping its pain with drugs or alcohol. Acting out that is hostile, counterphobic and/or a cry-for-help phenomenon may begin in adolescence and continue into early adulthood, especially if it is incorporated into a delinquent identity formation (Lamb, 1978). Depression, sometimes accompanied by an eating disorder, is also fairly

common in adolescents who are experiencing difficulty with separation from parents, especially in situations where one or both parents view the girl's normal striving for emotional independence as being a rejection and make her feel guilty for it.

Incest is one of the serious childhood traumas that can be mastered in late adolescence or sealed over and carried into adulthood with its potential to create disturbance remaining intact. There is evidence that many incest victims do find satisfactory resolutions of their trauma, usually through informal "therapeutic" relationships in which they can reveal their incest background and receive validation and support (Tsai, Feldman-Summers, & Edgar, 1979). Nevertheless, on the basis of my experience with adult incest survivors in psychotherapy, I suspect that the sealing over of incest trauma is much more common, perhaps due to a strong societal message that incest should be kept hidden plus the usual advice from friends and relatives to "put it all behind you," "get on with your life," "don't wallow in it!" and so forth.

Late adolescence-early adulthood would appear to be the age at which incest victims are least likely to obtain psychotherapy. When the incest trauma is fresh, in childhood or early adolescence, parents or other authority figures are in a position to insist that the child get professional help; many years later, from the perspective of middle adulthood, the victim/survivor

herself may be willing to admit that the incest trauma still needs to be worked through and seek therapy voluntarily. But at the age in between childhood and adulthood, the fledgling adult is engrossed in her struggle for independence from her family, finding a committed romantic/sexual relationship, and coping with the work world and/or higher education. In order to handle the external demands upon her, the young woman is very likely to utilize avoidance and denial mechanisms to quell the residual psychological discomfort engendered by her incest experience.

The avoidance mechanisms that are employed are very diverse. In some cases, there may be a complete repression of the knowledge that incest occurred. More commonly, however, the knowledge is accessible to recall, but it is suppressed, the girl reporting that she tries not to think about it and denying that it has had any important effect on her life. This suppression can be aided by intense involvement with external activities of a positive and productive nature; the girl can become centered on school and community activities that bolster her self-esteem and foster the public image of being an undamaged survivor. However, at least in psychotherapy settings, it is more commonly observed that avoidance is aided by the use of alcohol and recreational drugs, often accompanied by sexual acting out which is multiply determined by a confusion of sex with affection, hostility toward parents, and/or the need to obtain money or drugs. At the end of this process, the young woman has formed a negative identity that

is self-perpetuating, and we can truly say of her that the "cure" has proved to be worse than the disease! (Meiselman, 1978).

Of the small minority of incest background women who enter psychotherapy in late adolescence, many are only briefly shaken out of their habitual denial stance by interpersonal crises, as in these two cases:

> Linda, 21, held a full-time clerical job and was living with her parents and younger brother when she sought therapy in the midst of a family crisis following her mother's discovery of a letter from her Lesbian lover. She was fearful that her parents would cut off relations with her and felt extremely guilty about hurting her mother, whom she perceived to be in poor health.
>
> Born to very young parents, Linda was often beaten with belts by both of them throughout childhood and early adolescence. Father was alcoholic, sexually promiscuous and threatening to family members; mother was controlling and instrusive but also more supportive of Linda. Linda was sexually abused by an uncle throughout her childhood but did not tell her mother because she feared severe punishment. At 10, the uncle threatened her with a gun and she finally told her mother, who then protected her from the uncle.
>
> Linda was a behavior problem in school at every level, being insubordinate and frequently truant. She dated boys in high school but felt extremely guilty about having sexual intercourse with them and began to have a Lesbian affair at about 17. Drinking became a problem in high school, as did occasional suicidal gestures and explosive hostility when intoxicated, but these episodes did not bring about maternal rejection.
>
> Linda's mother was seen for one session and took the adamant position that Linda must have purposely wanted to hurt her because she had kept the letter from her lover knowing that her mother was in the habit of reading her mail. She also insisted that Linda's sexual preference was a conscious choice that represented a rejection of her family.

When Linda was seen for a second, and final, session she was still hoping that her mother would accept her as a gay woman but was rather obviously preparing the ground for a retraction of her confession. She said she wanted to think about becoming heterosexual again since she valued traditional family life so highly.

Marilyn, 19, was seen for two sessions, following one session with her mother, who had made the initial contact. Both mother and daughter had been shocked by the outcome of a recent argument in which Marilyn had used abusive language with her stepfather and exited telling her mother to "Ask him about the games we used to play!" She later told her mother more directly that the stepfather had engaged her in sex play between the ages of 9 and 12, but the stepfather, when confronted, insisted that Marilyn had misconstrued his fatherly warmth and attention. The mother then sought a therapy referral, not knowing whom to believe and confessing at the end of the interview that she "just wanted it all to go away!"

At the time she was seen, Marilyn was living with her mother, stepfather, and younger half brother. She gave a history of her parents divorcing when she was three and being placed in day care so that her mother could work. Her mother was admired for her competence and strength but perceived as distant and unavailable. When her mother met and married her second husband, Marilyn was delighted because she got much more attention from both parents after the marriage. Her stepfather's "touching games" made her uneasy but she did not tell her mother about them because she didn't want to ruin a relationship that made her mother happy. Her stepfather stopped touching her with the onset of adolescence; however, their relationship became increasingly hostile through the years, with many instances of open fighting like the one that culminated in her disclosure of incest.

When seen for her first session, Marilyn expressed a desire to pursue psychotherapy in order to learn how to deal with her anger at her stepfather without becoming explosive. She denied having problems in other areas. At the end of her first session, she stated that she was deeply ashamed that she had made her mother so unhappy and that she wished she could "take it all back."

In her second session, Marilyn reported enthusiastically on her progress in all areas of her life. She considered the disclosure incident to be a closed book and wished to concentrate on getting through college while keeping the peace at home.

In the following two cases, therapeutic contact was maintained for relatively longer time periods, perhaps because the young women had already experienced significant pain as a result of their maladaptive denial mechanisms:

Denise was 22 years old, a part-time college student and department store clerk, living with her divorced mother at the time she sought therapy. She appeared to be moderately depressed, reporting difficulty sleeping, drinking bouts, and alarming thoughts about suicide. She had recently lost her boyfriend and was also upset about her mother's romantic involvement with her paternal uncle. Having read a popular magazine article on incest, she connected her self-destructiveness to her relationship with her maternal grandfather and stated specifically that she wished to work on incest in therapy.

Denise was born when her mother was 19, her parents having separated before her birth. Her father was severely alcoholic and came from a family fraught with bizarre and anti-social behavior. He completely ignored Denise for ten years, then obtained visitation rights, had several visits and abandoned her again, leaving her bitterly resentful. Her mother was a vigorous, competent but "unmotherly" woman, who was still very much attached to her own mother and frequently left Denise with her grandparents while she worked. During these visits, the alcoholic grandfather regularly engaged Denise in genital manipulation between the ages of 4 and 10. She put up increasingly strong resistance to going to his house but was afraid to tell her mother why she hated to go there.

As an adolescent, Denise began to have sexual intercourse with a male cousin at age 13 and became very centered on her appearance and ability to attract men, especially if she could win a man away from another woman. She also enjoyed shocking others with

her drinking and sexually provocative behavior, and her mother frequently told her that she was just like her father and his family. After high school, she moved out of town for two years with a boyfriend who proved to be physically and sexually abusive. Her mother "disowned" her but then allowed her to move back to her house in order to attend college.

Denise was regular in her attendance at weekly psychotherapy sessions over a seven month period despite the fact that her personal life continued to be punctuated by episodes of drinking and impulsive vindictiveness toward anyone who hurt her feelings. After two months, she decided to tell her mother about the incest and was believed but did not receive the motherly kind of emotional response she had hoped for. Her resentment toward her mother remained a frequent focus throughout her therapy.

Denise was gradually able to examine some areas that evoked intense feelings of shame, notably the memory of the secret feeling of power she experienced when she was able to manipulate her grandfather into giving her special treats by threatening to disclose the incest and his clandestine drinking. She gained considerable intellectual understanding of how her incest guilt, identification with her father's aberrant behavior, and labelling by her mother had promoted the formation of a "black sheep" identity. Although she also appeared to understand her fear of intimacy with men, she went through three whirlwind romances, each of which ended with a very hostile withdrawal by her, during the short course of our therapy and withdrew from therapy abruptly to leave the area in pursuit of an older man of whom she knew her mother would strongly disapprove.

Cathy, 20, had just completed a residential treatment program for her alcohol and cocaine addictions. Her friends had strongly recommended that she have psychotherapy in order to work on her incest background. After delaying a few weeks, she presented herself with complaints of fearfulness, discomfort in many social situations, moodiness, difficulties with impulse control, and obvious ambivalence about entering therapy.

The first of three children born to parents who married at 19, Cathy characterized her family as having

"generations of child abuse!" Her mother had a history of physical and sexual abuse by an uncle and then was physically abused by Cathy's father and developed serious mental problems that persisted throughout Cathy's childhood and were associated with physical abuse of Cathy that the mother cannot now remember. Cathy has partial memory of several incidents of sexual abuse by her father when she was about seven years old and believes that vaginal intercourse occurred. There were also many other incidents of sexual abuse by friends, neighbors, and babysitters, all of whom acted as if it were "their right." Her parents having divorced when she was ten, the remainder of Cathy's childhood and adolescence was spent shuttling back and forth between her mother and other relatives, with some intervals with her father in which she perceived his sexual interest but did not allow incest to recur. From age 12 she was heavily involved with alcohol and cocaine and would have sexual intercourse with much older men (but only when intoxicated) in order to get her drugs. Among her many sexual affairs was a two year Lesbian relationship during which she "hated men." At age 19, she had become disgusted with her chaotic lifestyle and sought treatment for her addictions.

Cathy was in therapy for 11 months, during which time she was living with her mother and stepfather and attending junior college. It rapidly became apparent that Cathy's initial appearance of sophistication was an attempt to hide strong feelings of shyness and social awkwardness which had never been mastered because of her drug use, and her sessions often became discussions of how she could handle day-to-day social predicaments. I rapidly became her "good mother," providing her with supportive guidance and practical information about coping with life while sober. It also became obvious to both of us that she was subject to sudden high and low mood states and needed to develop cognitive, as opposed to chemical, ways of coping with these swings.

Anger and sadness associated with her mother's early physical abuse and neglect were often the focus of sessions. Her continuing difficulty with impulsive behavior was also manifested in repeated failures to use contraception, resulting in one abortion, several scares, and much therapeutic work on her lack of assertiveness in sexual situations and her tendency to rationalize immediate pleasure seeking. We also worked

> on her repetitive pattern of attempting to seduce older men, as if searching for a father figure who can refuse to be sexualized. Therapy was punctuated by various types of wishful thinking about magical ways to escape her problems--to move to a different city, to reestablish her rejected Lesbian identity, to find another man who would take care of her financially but not require her to have sex.
>
> Cathy terminated suddenly just after her twenty-first birthday, an occasion when she rationalized taking a drink to celebrate. She returned to an alcoholism treatment program to reestablish her sobriety before attempting therapy again.

All four of these cases illustrate the use of denial mechanisms that were, I believe, eventually destined to break down. Marilyn was heavily invested in maintaining a supernormal facade in public at the cost of private emotional explosions; the other three had developed drinking problems in mid-adolescence that had effectively stunted their psychological development. In fact, they manifested what I like to call the "black sheep identity disorder," characterized by misuse of alcohol and drugs, an erratic educational and occupational history, and numerous interpersonal scrapes in family and love relationships. Despite all these difficulties, however, they had never fun afoul of the law, so terming them "delinquent" would be somewhat misleading.

These "black sheep" clients tended to identify with family members who had hurt them. Denise, for instance, had been told since childhood that she was very similar to the alcoholic father who had abandoned her, and she incorporated into her self-concept

the belief that she would manifest some of the aberrant and downright bizarre behavior that her father's family was known for. Cathy, on the other hand, often compared herself to her mother and was quick to point out that the maternal side of her family was fraught with mental illness and child abuse. These faulty identifications were a frequent focus for therapy sessions, since they seemed to be developing into self-fulfilling prophecies.

In all four of these cases, the young woman was strongly attached to her mother and yet deeply ambivalent about her. In the two brief cases, a threatened disruption of the mother-daughter relationship as a result of a hostile gesture by the daughter was the precipitating event that caused high levels of anxiety in the daughter, motivating brief therapeutic contact. In each instance, the daughter's solution was to save the relationship by contriving to allow her mother to continue to believe that there were no serious difficulties. In the longer cases, Denise and Cathy, possible confrontation of the mother about feelings of abandonment and previously undisclosed events of childhood was a frequent focus of therapy sessions; also, both women were grieving the lack of maternal warmth and protectiveness that they had experienced as children and adolescents.

In her study of psychotherapy with incest survivors, Judith Herman (1981) remarked that anger at the mother typically precedes anger at a male perpetrator and that therapy is stymied

if the client is not allowed to work through her feelings about the mother-daughter relationship. The therapist must be willing to hear out the mother-directed anger, and this can be a point of difficulty for the feminist therapist who recoils from the mother-blaming attitudes that have permeated the old school psychiatric literature. It may be helpful to view the resolution of conflicts about the mother and achievement of age-appropriate separation from her as being the necessary preconditions for direction of anger at the perpetrator of incest.

Another focus of therapeutic work with the two longer term cases was the repeated occurrence of intense romantic relationships with a brief honeymoon period followed immediately by angry devaluation of the boyfriend and sometimes accompanied by acts of impulsive hostility. Both Denise and Cathy managed to go through this cycle three or four times apiece in therapy that lasted less than a year, giving the distinct impression that their psychological age was closer to 16 than 21. Their extreme need to have a boyfriend at all times, to attract men at any cost to themselves, and to develop exaggerated expectancies after very brief experience with a new person were often discussed and supportively interpreted, and it can be said that their relationships became somewhat less destructive, if not more durable, in the course of therapy.

A final theme, among many that might be mentioned, concerns the repetitive "rescue fantasies" that Blos (1962) has described

in the postadolescent phase of development. There was a great deal of emphasis on the hope that their mothers would finally understand them and that the perfect man would somehow materialize to take care of them and magically heal the wounds of childhood. The therapist needed to very specifically enunciate the belief that the young woman was capable of redefining her identity in more positive terms even if her mother never changed and "Mr. Right" remained a pipe dream. Urging the assumption of personal responsibility for her future, while helping her to avoid a severely self-punitive attitude toward her past errors of judgment, is the delicate stance that a therapist must take in attempting to diminish the rescue fantasy.

The cases described here were all seen in individual therapy, with some collateral family contacts, simply due to the nature of the private practice treatment setting. It should be noted that group therapy and the self-help, peer confrontation approaches have also been widely recommended, especially given the susceptibility of adolescent girls to peer influence (Herman, 1981; Lamb, 1978; Thorman, 1983).

Whether in group or individual therapy, it is important for the young incest survivor to have a caring adult to relate to as she gradually separates from her mother and attempts to revise her faulty identity formation. Whether the therapist is male or female, the incest victim will greatly benefit from the discovery that a warm interpersonal relationship can exist without sexual

acting out (Gottlieb & Dean, 1981).

As other authors (Lamb, 1979) have suggested, girls in late adolescence require an active, involved therapist, one who is willing to engage in an appropriate amount of self-disclosure in regard to her values and interpretation of human behavior. A cognitive or rational/emotive approach fits this age group rather well, since it actively emphasizes the concept that the incest survivor can make choices of how to respond to her strong emotions. It also allows the therapist to suggest alternative beliefs and to openly question the maladaptive self-concept that she has formed in response to the incest experience. In late adolescence, also, girls have usually developed the intellectual abilities for abstract reasoning that make this therapeutic approach possible. Discussions about such issues as self-control, selfishness, and the meaning of love are of great benefit at this age, and the therapeutic relationship may be the girl's only opportunity to reveal and then revise her beliefs without being blamed or preached to.

Finally, I feel that it is important for therapists who deal with this age group to cultivate in themselves a long-term time perspective with regard to the resolution of incest related trauma. Since it is common, if not actually prevalent, for the incest victim to utilize avoidance and denial techniques for as long as these mechanisms will work to reduce pain, it should not be surprising to find that she will reinstitute these familiar techniques when an acute emotional crisis resolves.

This return to denial can be supremely frustrating to a therapist who has learned just enough about the victim to sense how many changes will eventually be required. This frustration can be greatly reduced, if not totally eliminated, by thinking of the incest victim/survivor as a person who is making changes at her own rate and will most probably re-emerge from denial at some future time when she is again motivated to take stock of her life. The right kind of psychotherapeutic input in late adolescence-early adulthood can make her eventual working through of incest trauma much more probable.

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